2163

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico Co
City or town Salisbury Rt. 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD 2.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Maurice Clifton Anderson III

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	

6.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1947

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 10 70 min.

9. Birthplace Salisbury (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Maurice Clifton Anderson Jr.
13. Birthplace Pocomoke City, Md.

MOTHER
14. Maiden name Bernice Gattis Anderson
15. Birthplace Quantico, Wicomico Co. Md.

16. Informant Mrs Bernice Anderson
Address Christfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-9-47 (month) (day) (year)
Cemetery or crematory Pt. Waters
Location Quantico, Md.

18. Funeral director Father & Maurice Anderson, Jr.
Address acting Crisfield, Md

19. 6-26-47 (Date rec'd by registrar) Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 19 47, at 8 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Atelectasis	
Premature (6 months)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Purnell, MD
M. D. or other
Address 106 W. Main Date signed 5-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02096

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Penn Gen. Hospital
How long in hospital or institution? 4 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Armstrong

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	widower

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years: 77 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John Armstrong
13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Mary Davis
15. Birthplace: Maryland.

16. Informant: Annie M. Armstrong
Address: Whaleyville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 15, 1947 (month) (day) (year)
Cemetery or crematory: Pullets Chapel
Location: Whaleyville Md.

18. Funeral director: M. Parker Watson
Address: Selbyville, Del

19. 2/18 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1947, at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.... to — 19....
and that I last saw h... alive on ... 19....

Immediate cause of death	DURATION
Burns & heart	6 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Feb 12 '47
Where did injury occur? Whaleyville (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?): Home.
Means of injury: Burns by fire Injured at work? No

23. SIGNATURE: John L. Riley Dep. Med Exam
M. D. or other
Address: Snow Hill Md Date signed: 2/13/47

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02097

Reg. Dist. No. 983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Pittsville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry Author

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Anna Louise Author
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 11 - 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	1	15		

9. Birthplace: Long Island N. Y. (Town, county, and state)
10. Usual occupation: Merchantise Agency
11. Industry or business: reporter in N.J. & N.Y.
FATHER 12. Name: Rube Author
FATHER 13. Birthplace: Long Island N.Y.
MOTHER 14. Maiden name: Anna Louise Ferguson
MOTHER 15. Birthplace: England
16. Informant: Mrs Charlotte Edge
Address: Pittsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 1-1947 (month) (day) (year)
Cemetery or crematory: Pine M E Cemetary
Location: Near Whitesville Del
18. Funeral director: Wm Howard Wells
Address: Pittsville Md
19. 2/27 19 47 Received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1947, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1947, to Feb 26 1947
and that I last saw h.. alive on Feb 25 1947

Immediate cause of death	DURATION
Carcinoma bladder	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: Floyd A Insley M. D., or other
Address: Salisbury Md Date signed 2-26-47

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-5)

02098

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County: Wicomico

City or town: Powellville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ onths

Hospital, Institution, or street address where death occurred:
Powellville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rowena B. Bethard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: E. Murray Bethard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1870

8. AGE: Years	Months	Days	If less than one day
77	0	21	hrs. min.

9. Birthplace: Berlin, Worcester Co. Md.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER
12. Name: George Brittingham
13. Birthplace: Worcester Co. Md.

MOTHER
14. Maiden name: Catherine Davis
15. Birthplace: Worcester Co. Md.

16. Informant: Mrs J. O. Powell

Address: Powellville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland.

19. 2/20, 19 47 Harriet L. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17, 1947 at 9.33P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-9-1946 to Feb. 17 1947 and that I last saw h alive on Feb. 17, 1947

Immediate cause of death	DURATION
cerebral hemorrhage	1 week
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank D. Lewis M.D.
M. D. or other

Address: Willards, Md. Date signed 2-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02099.

Reg. Dist. No. 2330

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 hours 30 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BIRELEY, GUY WILLIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1947

8. AGE: Years: 0 | Months: 0 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Berlin, Wor. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Earl Bireley
13. Birthplace: Penn.

MOTHER
14. Maiden name: Florence Willis
15. Birthplace: Maryland

16. Informant: Mr. Earl Bireley
Address: Berlin Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 2/20/47 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin Md

18. Funeral director: Dunn & Burbage
Address: Berlin Md.

19. 2/20, 1947 (Date rec'd by registrar) Harris T. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 February 1947 at 10:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Feb. 1947 to 18 Feb. 1947 and that I last saw him alive on 18 Feb. 1947

Immediate cause of death	DURATION
Erythroblastosis fetalis	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Confirms diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Kines, M.D.
M. D. or other
Address: Salisbury, Maryland Date signed: 19 Feb. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-1 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02100

Reg. Dist. No. 2350

1. PLACE OF DEATH:

County Wicomico

City or town Sharptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County

City or town Barnstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME J. Winfield Bradley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10 1872

8. AGE: Years	Months	Days	If less than one day
74	3	23	hrs. min.

9. Birthplace Wicomico Co. Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Benjamin S. Bradley

13. Birthplace Wicomico County

MOTHER 14. Maiden name Hester Bradley

15. Birthplace Sussex County, Del.

16. Informant Mrs. O. N. Bennett

Address Sharptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/4/47 (month) (day) (year)

Cemetery or crematory Taylor Cemetery

Location Sharptown, Md.

18. Funeral director Spencer Bros

Address Sharptown Md.

19. 2-5 1947 (Date rec'd by registrar) Walter G. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1947, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1945 to Feb 2 1947 and that I last saw him alive on Feb 1 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to	
Due to	
Other conditions Acute Nephritis	10 days

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Kuhlman M. D. or other

Address Sharptown Md. Date signed 2/4/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

+ 02101

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Wicomico

County

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 800 Hill Street.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 800 Hill Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Estelle Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Theodore T. Clark

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 22nd 1877

8. AGE:

Years	Months	Days	If less than one day
69	3	22	____ hrs. ____ min.

9. Birthplace Middletown Md.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business At Home

FATHER
12. Name Lewis S. Taylor
13. Birthplace Worcester Co. Md.

MOTHER
14. Maiden name Sarah Jane Devereux
15. Birthplace Worcester Co. Md.

16. Informant Mr. Milton J. Clark
Address 800 Hill St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17-47 (month) (day) (year)

Cemetery or crematory Wicomico Mem. Park

Location Salisbury Md.

18. Funeral director Hellmuth & Walter R. Hellmuth

Address Salisbury Md.

19. 2/17/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14 1947, to 2/14 1947

and that I last saw her alive on 2/14 1947.

	DURATION
Immediate cause of death Chronic Myocarditis, C.V.D.	several weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. T. Trimble M.D.
M. D. or other

Address Salisbury Md. Date signed 2/15 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-d

02102

CERTIFICATE OF DEATH

Reg. Diat. No. 335

1. PLACE OF DEATH:

County Wicomico

City or town Sharptown - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:
Sharptown - Laurel Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Sharptown - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sharptown - Laurel Road
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Ernest H. Davis

3. (b) Social Security Number 220-12-2468

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 25, 1925

8. AGE: Years	Months	Days	If less than one day
21	9	21	...hrs. ...min.

9. Birthplace Vienna Maryland
(Town, county, and state)

10. Usual occupation Day laborer

11. Industry or business Marine Package Company

FATHER 12. Name No data

13. Birthplace

MOTHER 14. Maiden name Brookie Davis

15. Birthplace Sharptown, Maryland

16. Informant Brookie Davis

Address Sharptown, Maryland

17. Burial Date thereof February 19, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sam Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J. J. Frampton & Son

Address Federalsburg, Maryland

19. Feb 19 19 47 Walter J. Mann
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 47 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 19 47 to Feb 16 19 47 and that I last saw h... alive on Feb 15 19 47

	DURATION
Immediate cause of death Intra cranial Tumor	3 Months
Unqualified; not known whether benign or malignant. C.O.D.	
Due to	
Due to	
Other conditions Wassermann test negative.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Kuhlman M. D.

Address Sharptown Md Date signed 2/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02103

Reg. Dist. No. 3930

1. PLACE OF DEATH
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P. H. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 705 Bay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Wilson Disharoon

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Sallie C. Disharoon
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb. 3rd 1874
8. AGE: Years: 73 Months: 0 Days: 3 If less than one day: ..... hrs. ..... min.
9. Birthplace: Worcester C. Maryland
(Town, county, and state)
10. Usual occupation: retired Farmer
11. Industry or business:
FATHER 12. Name: William Disharoon
13. Birthplace: near Snow Hill Maryland
MOTHER 14. Maiden name: Hettie Bailey
15. Birthplace: near Snow Hill Maryland
16. Informant: Mrs. Sallie C. Disharoon
Address: 705 Bay St. Salisbury, Md.
17. Burial, cremation, or removal. Which?: Burial Date thereof: Feb. 8-1947 (month) (day) (year)
Cemetery or crematory: Mt Zion Cemetery
Location: Worcester C. Whiton Md
18. Funeral director: Holloway & C. Walter P. Holloway
Address: Salisbury Maryland.
19. (Date rec'd by registrar) 2/8/47 Harriet J. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6th 1947 at 4.45 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1947, to Feb 6 1947
and that I last saw h.. alive on Feb 5, 1947
Immediate cause of death: Influenza & pneumonia C.R.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lewis E. Tull M. D. or other
Address: Salisbury Md Date signed 2-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02104

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 Lake St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Dixon.

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Col	married.

6.(b) Name of husband or wife: Julia Dixon

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years	Months	Days	If less than one day
82	-	-	..... hrs. ..... min.

9. Birthplace: Salisbury, Md.

(Town, county, and state)

10. Usual occupation: Waiter.

11. Industry or business: none

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: - -

MOTHER — 14. Maiden name: Caroline Dixon

MOTHER — 15. Birthplace: Salisbury, Md.

18. Informant: Julia Dixon

Address: 712 Lake St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/2/47 (month) (day) (year)

Cemetery or crematory: Hawtorne Cem.

Location: Salisbury, Md.

18. Funeral director: Booker M Leach

Address: Salisbury, Md.

19. 3/1/47 (Date rec'd by registrar) Cassie E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 1947 at 4. P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1947, to Feb 25 1947

and that I last saw h.. alive on Feb 1947

Immediate cause of death	DURATION
Lobar Pneumonia	9 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur L. Browne M.D. M. D. or other

Address: Salisbury Md. Date signed: 3-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02105

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Seaford - Rural (If outside city or town limits, write RURAL and give nearest town)
Street No.: Oak Grove (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Edward Donovan

3.(b) Social Security Number: 221-10-7078

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Myalle M. Donovan
6.(c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.): July 20, 1898
8. AGE: Years: 48 Months: 7 Days: 8 If less than one day: hrs. min.
9. Birthplace: Sussex County, Delaware (Town, county, and state)
10. Usual occupation: Day Laborer
11. Industry or business: Farming Factory
FATHER 12. Name: James Donovan
FATHER 13. Birthplace: Sussex County, Delaware
MOTHER 14. Maiden name: Lillie Wheeler
MOTHER 15. Birthplace: Sussex County, Delaware
16. Informant: Mrs. Myalle M. Donovan
Address: Seaford, Delaware, R.F.D.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: 3/3/47 (month) (day) (year)
Cemetery or crematory: Eldorado Cem'y
Location: Eldorado, Md.
18. Funeral director: J. D. Crampton & Son
Address: Federalsburg, Md.
19. 3/3/1947 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 1947, at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1947 to Feb. 28 1947 and that I last saw h. alive on Feb. 28 1947
Immediate cause of death: Hemorrhage from Duodenal Ulcer — DURATION: Symptoms 28 days
Due to:
Due to:
Other conditions: Pulmonary abscesses Obstruction of Biliary tract (Include pregnancy within 3 months of death)
Major findings of operation: Duodenal Ulcer with Hemorrhage from pancreatic artery Date of op. Feb. 11, 1947
Autopsy results: See above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: David L. Gilmore M.D. (M. D. or other)
Address: 301 N. Division Salisbury, Md. Date signed: Feb. 28, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-3'5-

Dr. France

02106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 years
Hospital, institution, or street address where death occurred: 406 E. Isabella St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 406 E. Isabella St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Driscoll

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Bertha Driscoll
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.): March 29th 1879

8. AGE: Years 67, Months 10, Days 3. If less than one day ...hrs. ...min.

9. Birthplace: near Powellville Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Taxi operator
FATHER 12. Name: John Driscoll
13. Birthplace: R.D. Salisbury, Md.
MOTHER 14. Maiden name: Mary Jane Dennis
15. Birthplace: near Berlin Maryland
16. Informant: Miss Ronie Driscoll
Address: R.D. #2. Salisbury Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 15-47 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Holloway & [illegible] Walter R. Holloway
Address: Salisbury Maryland
19. 2/4/ 19 47. Harriet [illegible] Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2nd 19 47, at 4:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...
and that I last saw him alive on 2/2 19 47

Immediate cause of death: Coronary Occlusion — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: F. R. France, M.D. (M. D. or other)
Address: Salisbury, Md. Date signed 2/2/47.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

02107

Reg. Dist. No. 336

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 months
Hospital, institution, or street address where death occurred: 715 Davis street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #4.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Allen Wilbur Dryden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Lettie Dryden
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 5 ± 1867

8. AGE:

Years	Months	Days	If less than one day
79	2	26	...hrs. ...min.

9. Birthplace: R.D. Salisbury Md.
(Town, county and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Isaac Wilbur Dryden
13. Birthplace: RD #4. Salisbury, Md

MOTHER
14. Maiden name: Elmira Nepsick
15. Birthplace: Somerset Co. Maryland

16. Informant: Mr. Marion S. Bryan
Address: RD. #4 Salisbury Maryland
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb 4 47 (month) (day) (year)
Cemetery or crematory: Dryden Cemetery
Location: Ernest Dryden Farm Maryland
18. Funeral director: Hellings & Walter Salisbury Md.
Address: Salisbury Maryland
19. 2/4 1947 (Date rec'd by registrar) Carrie L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1st 1947, at 6.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1 1947, to 2/1 1947
and that I last saw him alive on 2/1 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr.
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ...Injured at work?

23. SIGNATURE: Elmer F. Fowler M.D.
M. D. or other
Address: Salisbury Md. Date signed: 2/4 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Correct date of birth
Unable to obtain

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

02108

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 607 School street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 607 School Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Georgiana Bullett

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: George Bullett
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Jan. 12th 1863
8. AGE: Years: 82 Months: 0 Days: 26 If less than one day: hrs. min.
9. Birthplace: Allen Md. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
FATHER 12. Name: Christopher Fossman
FATHER 13. Birthplace: Allen Md.
MOTHER 14. Maiden name: Nancy Willing
MOTHER 15. Birthplace: Somerset Co. Md.
16. Informant: Mr. Joseph A. Bullett
Address: 607 School st Salisbury Md.
17. Burial, cremation, or removal. Which?: Burial Date thereof: Feb. 11 1947 (month) (day) (year)
Cemetery or crematory: Donohoe Fam. Cem.
Location: Athol Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.
19. (Date rec'd by registrar): 2/11/47 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8th 1947, at 3:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941 to Feb 8 1947 and that I last saw her alive on Feb 8 1947
Immediate cause of death: Intestinal Hemorrhage — DURATION
Due to: Unknown Cause of intestinal hemorrhage
Due to: No known Cause — Unknown
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. A. Fowler M. D. or other
Address: Salisbury Md. Date signed: 2-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02109

CERTIFICATE OF DEATH

Reg. Diat. No. 3396

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, Institution, or street address where death occurred: U.S. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME Lillian A. Harris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Ralph H. Harris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 3 - 1882

8. AGE: Years 65 | Months 0 | Days 6 | If less than one day: hrs. min.

9. Birthplace: Pocomoke City, Somerset Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Henry N. Henderson
13. Birthplace: Md.
MOTHER 14. Maiden name: Amanda Merrill
15. Birthplace: Md.
16. Informant: Ralph H. Harris
Address: Hemdridge, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11 '47 (month) (day) (year)
Cemetery or crematory: Pocomoke City Md.
Location
18. Funeral director: Elmer C. Timmons
Address: Snow Hill, Md.
19. 2/11/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 1947 at 4 A M
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Feb. 4 1947 to Feb. 9 1947
and that I last saw h[illegible] alive on Feb. 8 1947.

Immediate cause of death	DURATION
Lobar Pneumonia	3 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis L. Llewellyn, M.D. M. D. or other
Address: Pocomoke City Date signed: 2-10-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02110

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: RD #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Colman Hoopes

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Anna M. Hoopes
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Dec. 3rd 1881

8. AGE:

Years	Months	Days	If less than one day
65	2	22	hrs. min.

9. Birthplace: Perryman Maryland (Town, county, and state)
10. Usual occupation: Retired Engineer
11. Industry or business: B. & O. R.R. Co.

FATHER
12. Name: James David Hoopes
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Mary Russell
15. Birthplace: Perryman Md.

16. Informant: Mrs. Anna M. Hoopes
Address: RD #2. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27-1947 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 2/27/ 19 47 (Date rec'd by registrar) H. L. Hallowell, Ey Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25th 1947, at 10:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1947, to Feb. 25 1947
and that I last saw him alive on Feb. 23 1947

Immediate cause of death: Coronary Occlusion

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William D. Gray, M.D. M. D. or other
Address Salisbury, Md Date signed 2/25/47

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02111

CERTIFICATE OF DEATH

Reg. Dist. No. 3990

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No.: Mrs. Monteiro (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mildred Martha Horner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Earl Russel Horner

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Oct 17, 1915

8. AGE: Years	Months	Days	If less than one day
31	3	22	..... hrs. ..... min.

9. Birthplace: Laurel, Delaware (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Husband

Address: Berlin, Md.

17. (Burial, cremation, or removal. Which?) Burial. Date thereof: Feby 11-47 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Laurel, Dela.

18. Funeral director: J. Raney Williams

Address: Georgetown - Md

19. (Date rec'd by registrar) 2/11/47 H. T. Hastie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 19 47, at 6 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1946 to Feb 8 1947 and that I last saw h.. alive on Feb 8 1947

Immediate cause of death	DURATION
Pulmonary Embolism	5 min.
Due to: Rheumatic Heart Disease	2
Due to:	
Other conditions: Hyper thyroidism	2

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert L. Jones M.D. M. D. or other

Address: Montrose, Md. Date signed 2-9-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 02112

CERTIFICATE OF DEATH

Reg. Diat. No. 3370

1. PLACE OF DEATH:
County: Wicomico
City or town: Wetipquin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
at home - Wetipquin, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: Maryland County: Wicomico
City or town: Wetipquin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: John R. Hull

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	married

6.(b) Name of husband or wife: Irene C. Hull
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-20-1868

8. AGE:

Years	Months	Days	If less than one day
78	11	2	hrs. min.

9. Birthplace: Wetipquin, Wicomico Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own business
FATHER 12. Name: Sidney Hull
13. Birthplace: Wetipquin, Maryland
MOTHER 14. Maiden name: Mary Horsey
15. Birthplace: Wetipquin, Maryland
16. Informant: Mrs. Rachel Whittington
Address: Wetipquin, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-25-47 (month) (day) (year)
Cemetery or crematory: Family Cemetery
Location: Wetipquin, Maryland
19. Funeral director: James T. Stewart
Address: 402 E. Church St., Salisbury Md
19. Feb 25 1947 (Date rec'd by registrar) R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-22 1947 at 2 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-22 1947, to 2-22 1947
and that I last saw him alive on 2-21 1947

	DURATION
Immediate cause of death: Cerebral Apoplexy	4 days
Due to: Hypertension	?
Due to: Arteriosclerosis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: E. A. Purnell, M. D. or other
Address: 800 W. Main St. Snow Hill, Md. Date signed: 2-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

Evidence for the date of cremation is shown on G 109 3/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02113

Reg. Dist. No. 3330

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JESTER

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) January 30 - 1947

8. AGE: Years | Months | Days: 6 | If less than one day: ... hrs. ... min.

9. Birthplace: Salisbury Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Wilson Lee Taylor

13. Birthplace

MOTHER 14. Maiden name: Anna mae Jester

15. Birthplace

16. Informant

Address

17. ✓ (Burial, cremation, or removal. Which?) Date thereof 2/7/47 (month) (day) (year)

Cemetery or crematory: Peninsula General Hospital

Location: Salisbury Md

18. Funeral director

Address: Salisbury Md.

19. 2/10 1947 Harriet L. Johnson Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH (6) 7 Feb. 1947, at 1.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Jan 1947, to 7 Feb. 1947 and that I last saw h[er] alive on 4 Feb. 1947

Immediate cause of death	DURATION
Interstitial pneumonia	3 days
Due to	
Due to	
Other conditions: Intra-Cranial hemorrhage, Uremia, Impetigo (Include pregnancy within 3 months of death)	Uremia 24 hours

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. W. Kerr, M.D. M. D. or other

Address: Salisbury, Md Date signed 8 Feb 47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02114

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 305 North Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Johnson - Mrs. S. Catherine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mr. Irvin Johnson
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 22, 1906

8. AGE: Years	Months	Days	If less than one day
40	8	22	...hrs. ...min.

9. Birthplace: Salisbury, Wicomico Co., Md
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER 12. Name: Louis L. Washburn
13. Birthplace: Wicomico Co., Md
MOTHER 14. Maiden name: Bertha M. Tilds
15. Birthplace: Wicomico Co., Md
16. Informant: Mrs. Irvin Johnson
Address: Salisbury, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/47 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md
18. Funeral director: The Hill & Johnson Co
Address: Salisbury, Md
19. 2/16, 1947 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1947, at 12:15 P. M.
21. I CERTIFY that death occurred on the date above stated: (b) I attended deceased from April, 1946, to Feb. 13, 1947
and that I last saw her alive on Feb. 13, 1947

Immediate cause of death	DURATION
Cardiac failure	
Due to: Cerebral Embolism	48 hrs
Due to: Endocarditis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Vegetative endocarditis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury. Injured at work?

23. SIGNATURE: Robert R. Starr M. D.
Address: Salisbury Date signed: 2-14-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (920)

02115

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, Institution, or street address where death occurred:
219 Newton St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 219 Newton St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Arthur Kennerly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Florence E. Kennerly
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): May, 16 1874.

8. AGE: Years	Months	Days	If less than one day
72	9	0	hrs. min.

9. Birthplace: Accomac Co. Va. (Town, county, and state)
10. Usual occupation: Laundry Operator
11. Industry or business

FATHER
12. Name: James Kennerly
13. Birthplace: Wicomico, Co Md.

MOTHER
14. Maiden name: Adeline White
15. Birthplace: Wicomico, Co. Md.

16. Informant: Mrs. W.A. Kennerly
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/ 19/ 47 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.

19. 2/19 (Date rec'd by registrar) 1947 Harriet E. Johnson Deal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16 19 47 at 5 30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 16 19 47 to Feb 16 19 47 and that I last saw him alive on Feb 15 19 47

	DURATION
Immediate cause of death: Pulmonary Heart Disease	2 yrs
Due to:	
Due to:	
Other conditions: Secondary Anemia	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

20. SIGNATURE: Lucien R. Mason M. D. or other
Address: Salisbury Md Date signed 2/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02116

Reg. Diat. No. 3[illegible]

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mths 6 days

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Leffew, Kathleen

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Single

6.(b) Name of husband or wife ✓

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): October 3, 1946

8. AGE: Years	Months	Days	If less than one day
	4	4	hrs. min.

9. Birthplace: Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Jessie L. Leffew

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Virginia M. Cottew

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Virginia M. Leffew

Address: Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 9, 1947 (month) (day) (year)

Cemetery or crematory: Bethany

Location: Pocomoke city, Md.

18. Funeral director: Margarette H. Watson

Address: Pocomoke city, Md.

19. 2/9 1947 (Date rec'd by registrar) Grace E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1947, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-21 1946, to 2-7 1947 and that I last saw her alive on 7 February 1947

Immediate cause of death	DURATION
Atelectasis left lung	40 days
Due to: Bronchopneumonia	16 days
Due to:	
Other conditions: Malnutrition	lifetime
Prolapse of rectum	40 days

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Cecil Kines M. D.
M. D. or other

Address: Salisbury, Md. Date signed: 8 Feb. 47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

02117

CERTIFICATE OF DEATH

Reg. Dist. No. 5300

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Wicomico
City or town Madola
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Madola
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John B. Marshall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
M.	W.	Married

6.(b) Name of husband or wife Eva Marshall
6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) March 8, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	27	hrs. min.

9. Birthplace Vienna, Wicomico Md.
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business
12. FATHER Name Major Marshall
13. Birthplace Vienna Md.
14. MOTHER Maiden name Melissa Carrington
15. Birthplace Vienna Md.
16. Informant Mrs. Eva Marshall
Address Madola Md.
17. Burial Date thereof 2/9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Madola Cem.
Location Madola Md.
18. Funeral director David R. Insley
Address Hebron Md.
19. 2/9/47 19 W. H. Robertson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/47 19 at 7:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2/4 19 46, to 2/4 19 47 and that I last saw h alive on 2/4 19 47

Immediate cause of death	DURATION
Arteriosclerosis -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Robertson M. D. or other
Address Sharptown Md Date signed 2/8/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

CERTIFICATE OF DEATH

1111 021133350

Reg. Dist. No.

1. PLACE OF DEATH:
County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wic
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hillard T. Massey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Jane E Massey
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Oct 20 1873

8. AGE:

Years	Months	Days	If less than one day
73	4	4	hrs. min.

9. Birthplace: Laurel R.D. Sussex Del (Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business:

FATHER
12. Name: Nehon Massey
13. Birthplace: Del

MOTHER
14. Maiden name: Annie Covington
15. Birthplace: Md

16. Informant: Jane E. Massey
Address: Sharptown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-27-1947 (month) (day) (year)
Cemetery or crematory: Firemans
Location: Sharptown
18. Funeral director: Graveling Bros
Address: Sharptown Md.

19. 2-27 1947 (Date rec'd by registrar) Wallis G. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1947, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936, to Feb 24 1947
and that I last saw him alive on Feb 24 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hrs
Due to: Arteriosclerosis	11 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: J T S Kuhlman M. D. or other
Address: Sharptown Md Date signed: 2/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-55

Dr. Kitto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02119

Reg. Dist. No. 3330

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Federalsburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near American Corner
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Milligan, Rebecca Louise

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 21, 1946

8. AGE:

Years	Months	Days	If less than one day
	2	3	hrs. min.

9. Birthplace: Preston, Maryland R.F.D.
(Town, county, and state)
10. Usual occupation: Infant
11. Industry or business: —

FATHER
12. Name: Norman E. Milligan
13. Birthplace: Hurlock, Maryland, R.F.D.

MOTHER
14. Maiden name: Mabel A. Seelers
15. Birthplace: Caroline County, Maryland

16. Informant: Norman E. Milligan
Address: Federalsburg, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 26 1947 (month) (day) (year)
Cemetery or crematory: Washington Cemetery
Location: Near Hurlock, Maryland

18. Funeral director: J. J. Frampton and Son
Address: Federalsburg, Maryland

19. 2/26, 1947 (Date rec'd by registrar) Harriet J. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24 1947 at 10 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Feb. 1947 to 24 Feb. 1947 and that I last saw h[illegible] alive on 24 Feb. 1947

Immediate cause of death	DURATION
Bilateral pneumonitis	1 week
Due to:	
Due to:	
Other conditions (1) Bilateral partial pulmonary atelectasis (2) Malnutrition (Include pregnancy within 3 months of death)	1 week, 1 week

Major findings of operations: —
Date of op.: —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Kitto, M.D. M. D. or other
Address: Salisbury, Md. Date signed: 25 Feb. 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Evidence for the change of year of birth is shown o n G 109 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

02120

Reg. Diat. No. 33/0

1. PLACE OF DEATH:

County: Wicomico

City or town: Quantico md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Quantico md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Sallie J. Mitchell

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a.a.	Married-Widow

6.(b) Name of husband or wife: Andrew Mitchell Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about ~~1866~~ 1868

8. AGE: Years	Months	Days	If less than one day
about 79			hrs. min.

9. Birthplace: Quantico md
(Town, county, and state)

10. Usual occupation: no-work Laborer-Work Housekeeping

11. Industry or business: Farm

FATHER
12. Name: Lindy Pinkett
13. Birthplace: Quantico

MOTHER
14. Maiden name: Mary Pinkett
15. Birthplace: Quantico

16. Informant: George A. Mitchell
Address: Quantico md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-28-47 (month) (day) (year)

Cemetery or crematory: Quantico

Location: Quantico md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. Feb 28 1947 (Date rec'd by registrar) Mrs J. M. Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1947, at 1.30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18th 1947, to Feb. 23rd 1947 and that I last saw h ee alive on February 23rd 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William Emrick M. D. or other

Address: Helron- Md Date signed: Feb. 27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02121

Reg. Dist. No. 3338

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware. County: Sussex

City or town: Laurel.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mitchell, Mr Thomas.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Widower

6.(b) Name of husband or wife: Ella Reed Mitchell

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): 3/17-1868

8. AGE: Years	Months	Days	If less than one day
78.	11	14	✓ hrs. ✓ min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: William Mitchell
13. Birthplace: Delaware

MOTHER
14. Maiden name: Mary E Mitchell
15. Birthplace: Delaware

16. Informant: Everett M Mitchell

Address: Laurel Delaware

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2-5-47 (month) (day) (year)

Cemetery or crematory: Odd Fellows Cemetery

Location: Laurel Delaware

18. Funeral director: J Harvey Williams

Address: Salisbury Md

19. 2/6 1947 (Date rec'd by registrar) Katherine E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/3 1947, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/23 1947, to 2/3 1947 and that I last saw him alive on 2/3 1947

Immediate cause of death	DURATION
Myocarditis	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. R. Grampe M.D. M. D. or other

Address: Salisbury Md Date signed 2/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

02122

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 413. Dana street,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 413. Dana street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Handy Nickerson | 3.(b) Social Security Number

4. Sex Male | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Hettie Brown Nickerson | 6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) March 1st 1872

8. AGE: Years 74 | Months 11 | Days 21 | If less than one day ....hrs. ....min.

9. Birthplace Pittsville Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business retired

FATHER 12. Name Henry Nickerson
13. Birthplace Pittsville Maryland

MOTHER 14. Maiden name Emma Brown
15. Birthplace Pittsville Maryland

16. Informant Mr. Ernest Nickerson
Address 204. Wilcomico st. Salisbury Md

17. Burial (Burial, cremation, or removal (Which?)) Date thereof Feb. 24-1947 (month) (day) (year)
Cemetery or crematory Charity church Cem
Location Near Salisbury Maryland

18. Funeral director Hillman & C. Walter R. Hillman
Address Salisbury Maryland.

19. 2/24/47 (Date rec'd by registrar) 19.... Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22nd 1947 at 3 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/8 1947, to 2/22 1947
and that I last saw h... alive on 2/8 1947

Immediate cause of death Diabetes | DURATION several years
Due to
Due to
Other conditions Diabetes Gangrene of foot
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. G. Fisher md M. D. or other
Address Salisbury md Date signed 2/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

02123

CERTIFICATE OF DEATH

Reg. Dist. No. 3350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Queenes
City or town: Chaptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Dist
City or town: Chaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ellen E. Owens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: George E. Owens
6.(c) If alive, give age: 81 years
7. Birth date of deceased (mo., day, yr.): Sept 3

8. AGE: Years: 77 Months: 5 Days: 11 If less than one day: hrs. min.

9. Birthplace: Chaptown Dist Md (Town, county, and state)
10. Usual occupation: House work
11. Industry or business:

MOTHER
12. Name: Isaac Morris
13. Birthplace: Del

FATHER
14. Maiden name: Frances E Wright
15. Birthplace: Md

16. Informant: Samuel H. Owens
Address: Chaptown

17. Burial (Burial, cremation, or removal—which?) Date thereof 2 16 1947 (month) (day) (year)
Cemetery or crematory: Friends
Location: Chaptown
18. Funeral director: Grason or Boos
Address: Chaptown

19. Feb 15 1947 (Date rec'd by registrar) Walter E Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1947, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Feb 14 1947 and that I last saw her alive on Feb 14 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other
Address: Harpstown Md Date signed 2/15/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

02124

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH: County: Wicomico; City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town); How long in above place of death?; Hospital, institution, or street address where death occurred:; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Md., County: Wicomico; City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town); Street No. (If rural, give LOCATION); 2.(a) If veteran, name war

3.(a) FULL NAME: Walter M. Owens

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife; 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 5- 1899

8. AGE: Years: 47; Months: 7; Days: 12; If less than one day: ... hrs. ... min.

9. Birthplace: Wocester C. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Charles W. Owens; 13. Birthplace: Wocester C. Md.

MOTHER — 14. Maiden name: Hettie Ann Adkins; 15. Birthplace: Near Snow Hill Md.

16. Informant: Mr. Charles W. Owens; Address: Fruitland Maryland.

17. Burial, cremation, or removal. Which?: Burial; Date thereof: Feb. 19-1947 (month) (day) (year)

Cemetery or crematory: Experience Cem; Location: Princess Anne Md

18. Funeral director: Holloway & Co. Walter R. Holloway; Address: Salisbury Maryland.

19. 2/19/47 (Date rec'd by registrar) 19 47 Charles E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17 1947, at 12 0 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Jan. 17, 1947, to Jan. 17, 1947 and that I last saw him alive on Jan. 17, 1947.

	DURATION
Immediate cause of death: Congestive Heart Failure	Last attack
Due to:	3 - hours
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Charles W. Trader M. D. or other

Address: Salisbury, Md. Date signed: 2-19-47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-a)

02125

CERTIFICATE OF DEATH

Reg. Diat. No. 3350

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Route #3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Salisbury Route #3 Zion Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury Route #3
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Wayne Alexander Price

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	Infant

6.(b) Name of husband or wife none

6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) 2-16-47

8. AGE: Years | Months | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Wicomico Co. Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Marion E. Price

13. Birthplace Accomac Virginia

MOTHER 14. Maiden name Lottie Cuffe

15. Birthplace Salisbury, Maryland

16. Informant Marion E. Price

Address Salisbury, Md. Route #3.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-21-47 (month) (day) (year)

Cemetery or crematory Glass Hill

Location Parsonsburg, Md.

18. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury Md.

19. 2/21/47 (Date received by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20- 19 47, at 10:50 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2-16 19 47, to 2-20 19 47

and that I last saw him alive on 2-19-47 19

Immediate cause of death Atelectasis — DURATION 4 days

Due to Under developed Respiratory apparatus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. A. Purnell M.D.
M. D. or other

Address 800 W. Main St. Date signed 2-21-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02126

Reg. Dist. No. 2330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 413 Dana street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 413 Dana street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Emily Purnell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Purnell
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): May 5th 1863

8. AGE: Years	Months	Days	If less than one day
83	9	5	...hrs. ...min.

9. Birthplace: Whiton Maryland
(Town, county, and state)

10. Usual occupation:
11. Industry or business: at Home

FATHER
12. Name: Silas Davis
13. Birthplace: Whiton Maryland

MOTHER
14. Maiden name: Sallie Jones
15. Birthplace: Whiton Maryland.

16. Informant: Mrs. Stella Clark
Address: 423 E. Williams St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 12-1947 (month) (day) (year)
Cemetery or crematory: Mt. Zion Church Cem.
Location: Whiton Maryland.

18. Funeral director: Holloway & G. Walter R. Holloway
Address: Salisbury Maryland.

19. 2/12/47 (Date rec'd by registrar) Harriet E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10th 1947 at 12 35 M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 28 1946 to February 10 1947 and that I last saw h.e. alive on February 10 1947

Immediate cause of death	DURATION
Cardiac Failure.	1 hr.
Due to Arteriosclerosis	2
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Stone M.D. M. D. or other
Address: Salisbury, Md. Date signed: 2-11-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02127

Reg. Diat. No. 3330

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico Co

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 224 3rd. St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Clemons, Gwendolyn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 6. 1947.

8. AGE: Years | Months | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Salisbury Md (Town, county and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: Fulton Clemons

FATHER — 13. Birthplace: Salisbury Md

MOTHER — 14. Maiden name: Catherine Bailey

MOTHER — 15. Birthplace: Baltimore City Md

18. Informant: Fulton Clemons

Address: 224 3rd st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/25/47 (month) (day) (year)

Cemetery or crematory: Newton Cem

Location: Salisbury Md.

18. Funeral director: Bookerton West

Address: Salisbury Md.

19. 2/25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-24 19 47 at 12 30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... and that I last saw h... alive on ..... 19.....

Immediate cause of death: Acute Pneumonia — DURATION: one day

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operation: None — Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Sarah Lee Johnson Deputy Med Examiner M. D. or other

Address: Salisbury Md Date signed 2/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02128

Reg. Diat. No. 3350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Hyconico
City or town: Sharpstown (If outside city or town limits, write RURAL and give nearest town) 13 months
How long in above place of death? 13 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Hyc
City or town: Sharpstown (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Florence E. Sliwinski

3.(b) Social Security Number:

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Alexander Sliwinski
6.(c) If alive, give age: 32 years
7. Birth date of deceased (mo., day, yr.): Aug 30 - 1912
8. AGE: Years: 34 Months: 6 Days: 6 If less than one day: hrs. min.
9. Birthplace: Galestown, Dor. Md (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business:
FATHER 12. Name: Herman C. Henry
13. Birthplace: Md.
MOTHER 14. Maiden name: Maggie Dunn
15. Birthplace: Md
16. Informant: Maggie D Henry
Address: Sharpstown Md
17. Burial (Burial, cremation, or removal—which?) Date thereof 2 7 1947 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Sharpstown Md.
18. Funeral director: Graves & Bros
Address: Sharpstown, Md.
19. 2-7 1947 (Date rec'd by registrar) Walter S Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-6 1947, at 11:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1 1947 to 2-4 1947 and that I last saw h[illegible] alive on 2-4 1947
Immediate cause of death: Carcinoma of Cervix Uteri — DURATION
Due to: Carcinomatosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles M Mogg M. D. or other
Address: Sharpstown Md Date signed 2-4-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0212?

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Ohio Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Smith, Mr. Edgar John Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Bertha Anne Smith

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): May 1st 1889

8. AGE: Years 57 | Months 9 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace: Wachapreague Virginia
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER — 12. Name: Edgar J. Smith

13. Birthplace: Eventville Va.

MOTHER — 14. Maiden name: Julia A. Meade

15. Birthplace: Painter Virginia

16. Informant: Mrs. Clyde A. Smith

Address: 205 Ohio Ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27-47 (Month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury, Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Maryland.

19. 2/27/47 (Date rec'd by registrar) 19... Harold E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 19 47, at 8:45 P M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 19 47, to Feb. 25 19 47

and that I last saw h... alive on Feb. 25 19 47

Immediate cause of death	DURATION
Lobar pneumonia, str.	
Due to	
Due to	
Other conditions: Mitral stenosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Pneumonia, entire st. lung; mitral stenosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

20. SIGNATURE: William H. Tilghman M.D.
M. D. or other

Address: Peninsula General Hospital Date signed: Feb 26 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-7)

CERTIFICATE OF DEATH

02130 3360

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

208 State St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 State St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Milton Alert Spangler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sulu F. Spangler

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1875

8. AGE: Years 71 | Months | Days | If less than one day hrs. min.

9. Birthplace Gettysburg Pa (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Shoe

FATHER 12. Name unknown

FATHER 13. Birthplace unknown

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Sulu F. Spangler

Address Delmar Del

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2-24-47 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Hanover, Pa

19. Funeral director W. S. Gravel Co

Address Delmar Del

19. Feb. 22 1947 Harry E. Hudson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Feb 21 1947 and that I last saw h. alive on Feb. 20 1947

Immediate cause of death	DURATION
Uremic Coma	3 days
Due to Chronic Nephritis	2 yrs
Due to Chronic Myocarditis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Lynch M. D. or other

Address Salisbury Md Date signed 2/24/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

02131

CERTIFICATE OF DEATH

Reg. Diat. No. 3330

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 New York Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Martha Ann Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Seymour R. Taylor

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct, 16, 1864.

8. AGE: Years	Months	Days	If less than one day
82	4	4	____ hrs. ____ min.

9. Birthplace: Purgittville West Va.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER
12. Name: Elijah Huffman
13. Birthplace: West, Va.

MOTHER
14. Maiden name: Sarah Elizabeth Taylor
15. Birthplace: West, Va.

16. Informant: Mrs Ethel Taylor Winfree

Address: 125 Dover St. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/22/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. 2/22/47 (Date rec'd by registrar) H. T. Hazzard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20, 1947, at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1947, to Feb 20 1947, and that I last saw h-- alive on Feb 20 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to:	
Due to:	
Other conditions: Fracture Hip	6 days
Due to: Accidental falls. Senile.	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: February 13, 1947

Where did injury occur? Salisbury, (City or town) Wicomico, (County) Maryland. (State)

Injured at home, farm, industry, public place (where?): at home.

Means of injury: Accidental falls Injured at work? Slipped on step.

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 2/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (550)

CERTIFICATE OF DEATH

Reg. Dist. No. 265   5330

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: TAYLOR, Merrill J.

3.(b) Social Security Number: None

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 3, 1945

8. AGE: Years 1, Months 8, Days 15. If less than one day ... hrs. ... min.

9. Birthplace: Crisfield Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Ira J Taylor

13. Birthplace: Va

MOTHER 14. Maiden name: Mary J Jones

15. Birthplace: Crisfield Md

16. Informant: Ira J. Taylor

Address: Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/21/47 (month) (day) (year)

Cemetery or crematory: Sunny Ridge

Location: Crisfield Md

18. Funeral director: Hanford H. Ward

Address: 306 Main St. Crisfield Md

19. 2/13/47 Arthur E. [illegible] (Date rec'd by local registrar) 5/13/47 Harriet E. Johnson, Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Feb. 1947 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 January 1947 to 18 Feb 1947 and that I last saw him alive on 18 Feb. 1947

Immediate cause of death: Neuroblastoma with metastases. — DURATION: 5 wk. from personal observation

Due to: Neuroblastoma left adrenal

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Biopsy of metastatic neuroblastoma of chest wall. Date of op. 16 Jan. 47

Autopsy results: Confirmed diagnosis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: A. C. Watts, M.D. (M. D. or other)

Address: Salisbury, Md. Date signed: 19 Feb. 47

VS 415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

02133

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 3330

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: P.B. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 229 Pine Street (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lelia H. Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Thomas
6.(c) If alive, give age 79 years
7. Birth date of deceased (mo., day, yr.) Jan. 10th 1879

8. AGE: Years	Months	Days	If less than one day
68	8	24	...hrs. ...min.

9. Birthplace Snow Hill Maryland (Town, county, and state)
10. Usual occupation Home wife
11. Industry or business at Home
FATHER 12. Name William Cannon Short
FATHER 13. Birthplace Near Snow Hill Maryland
MOTHER 14. Maiden name Sophia Taylor
MOTHER 15. Birthplace Near Snow Hill Maryland
16. Informant Mr. Clarence E. Lyarenes
Address 66 Norway Ave. Richardson Park Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7th 1947 (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury, Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland
19. 2/7/47 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th 1947 at 3 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1946 to Feb 4th 1947
and that I last saw h...alive on 2-4-47 1947

Immediate cause of death	DURATION
Hestric Hemorrhage	10 min.
Due to Esophageal Varicose.	2
Due to Hypertensive Cardio Vascular Disease	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Stone M.D. M. D. or other
Address Salisbury, Md Date signed 2-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

02134

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Shiloh Road
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Shiloh Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Agnes Mae Dorey

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Harry A. Dorey
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): Sept. 20 ± 1893

8. AGE: Years: 53 | Months: 4 | Days: 29 | If less than one day: ... hrs. ... min.

9. Birthplace: R.D. #4 Salisbury Md.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business: at Home

FATHER
12. Name: Alfred W. Riddick
13. Birthplace: R.D. #4. Salisbury Md.

MOTHER
14. Maiden name: Etta C. Dennis
15. Birthplace: Nanjo Maryland

16. Informant: Mr. Harry A Dorey
Address: Shiloh Road Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 22-1947 (month) (day) (year)
Cemetery or crematory: Wi. Co. Mem. Park
Location: Salisbury Maryland.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 2/22/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19 ± 1947 at 1050 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 19 1947 and that I last saw h... alive on Feb 19 1947

Immediate cause of death	DURATION
Carcinoma of Breast	3 yrs
Due to: Metastasis to Liver	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Nil
Date of op. 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury Date signed: 2/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

02135

Reg. Dist. No. 3310

1. PLACE OF DEATH:
County: Wicomico
City or town: Nelson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Nelson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Phyllis Juletta Townsend

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: John E. Townsend
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 6, 1876

8. AGE: Years: 70 | Months: 7 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Nelson Wicomico, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Benjamin Bradley
13. Birthplace: Snowhill, Md.

MOTHER
14. Maiden name: Talitha Phillips
15. Birthplace: Sharptown Md.

16. Informant: Mrs. Paul Townsend
Address: Nelson Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/5/47 (month) (day) (year)
Cemetery or crematory: Nelson Cemetery
Location: Nelson, Md.

18. Funeral director: David E. Mosick
Address: Nelson Md.

19. Feb 5 19 47 (Date rec'd by registrar) Mrs J M Wallop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3, 19 at 5:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 18 19 47, to February 2 19 47 and that I last saw h.. alive on February 2 19 47

Immediate cause of death	DURATION
Carcinoma of Breast with Metastases	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Nelson-Md. Date signed Feb 5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

02136

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, Institution, or street address where death occurred:
801 South Division St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 801 South Division St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Virginia Ellen Vincent

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Alfred L. Vincent

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June, 26, 1861.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	7	29		

9. Birthplace: Wicomico Co., Maryland.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: John E. Dykes
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Ellen Pryor
15. Birthplace: Wicomico Co. Md.

16. Informant: Mr. J. Morris Vincent
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. 2/26/47 (Date rec'd by registrar) 19.. H. T. Harris E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24, 1947 19.. at 2.30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw h.. alive on ..... 19..

Immediate cause of death: Coronary Thrombosis — DURATION: 24 hrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: None — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jas Rademaker MD Medical Examiner - Deputy (M. D. or other)

Address: Salisbury Md. Date signed 2/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02137

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 3370

1. PLACE OF DEATH:
County Wicomico
City or town Gesterville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Gesterville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roy Washington Walter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ella Horsman Walter
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.): March 23, 1891

8. AGE: Years	Months	Days	If less than one day
55	10	25	hrs. min.

9. Birthplace: Hollands Island, Dorchester Co. Md.
(Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER 12. Name: George W. Walter
13. Birthplace: Spring Island, Md.

MOTHER 14. Maiden name: Geraldine E. Fisher
15. Birthplace: ? - Dorchester Co.

16. Informant: Ella H. Walter
Address: Gesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/21/47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Oak Grove Cemetery

18. Funeral director: C. S. Messick
Address: Bivalve, Md.

19. Feb 22 1947 (Date rec'd by registrar) L. Bradford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18th 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15th 1947, to 1947
and that I last saw h.. alive on February 18, 1947

Immediate cause of death	DURATION
Coronary occlusion	1 hr
Due to: Arteriosclerosis + Hypertension	
Due to:	
Other conditions: Hemiplegia	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

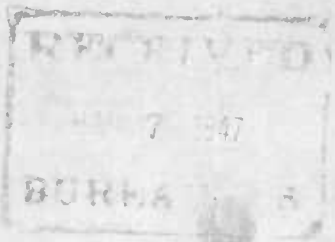
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. A. Stone. M. D. or other
Address: Pocomoke Date signed 2-23-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



2-35

Redmanden

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02138

Reg. Dist. No. 3350

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula Emgeal Hospital
How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worchester
City or town: Pocomoke, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wilson Dr. Frederick W.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Mrs Minnie S. Wilson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1875

8. AGE: Years: 71 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: Dr., of Medicine

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Mrs. Wilson
Address: Pocomoke City, Md.

17. burial — Date thereof 2-27-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Episcopal Cemetery
Location: Pocomoke City, Md.

18. Funeral director: Dale Duckfield
Address: Princess Anne, Md.

19. 2/26/47 — Clarence E. Johnson — Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947, to Feb. 25 1947
and that I last saw him alive on Feb. 25 1947

	DURATION
Immediate cause of death: Coronary Artery Heart Disease (Coronary occlusion)	Symptoms 3 months
Due to: Arteriosclerosis	
Due to:	
Other conditions: Pulmonary Embolis	Symptoms 3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: David J. Gilmore M.D.
M. D. or other
Address: 301 N. Division — Date signed: Feb. 25, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-7

CERTIFICATE OF DEATH

02139

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 11 weeks and 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Worcester.
City or town Berlin Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Workman, mrs. Elizabeth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John Workman
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 20th 1892

8. AGE: Years	Months	Days	If less than one day
54	8	17	hrs. min.

9. Birthplace Dagsboro Del
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joshua B Chandler
13. Birthplace Dagsboro Del
MOTHER 14. Maiden name Sarah J Hudson
15. Birthplace Delaware
16. Informant Milton Moore
Address Berlin Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 1947 (month) (day) (year)
Cemetery or crematory Red Mens, Dagsboro
Location Dagsboro Del
18. Funeral director Mrs John H Burbage
Address Berlin Md
19. 2/5 1947 (Date rec'd by registrar) Estelle J. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1947 at 1 55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 1946 to Feb 3 1947
and that I last saw her alive on Feb. 2 1947

Immediate cause of death	DURATION
Carcinoma of Liver	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of liver
Date of op. Nov 11, 1946
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE La Rademacher M D
M. D. or other
Address Salisbury Md Date signed 2/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

02140

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 North St
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Hettie Wright

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a. a.	Widow

6.(b) Name of husband or wife: Walter Wright (Don't name) Dead 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1882

8. AGE: Years: about 65 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Salisbury, Md. (Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business: Same as above

FATHER — 12. Name: Bayne Wood

FATHER — 13. Birthplace: Salisbury md

MOTHER — 14. Maiden name: Angelina Twent

MOTHER — 15. Birthplace: Salisbury md

16. Informant: John Walter

Address: Salisbury md

17. Burial, cremation, or removal. Which? Burial Date thereof (month) (day) (year): June 27-1947

Cemetery or crematory: Family

Location: Salisbury Md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. (Date rec'd by registrar) 2/27/47 Hassie E. Johnson (Signature of registrar) Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1947, at 8:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-21 1946, to 2-24 1947 and that I last saw h... alive on 2-24-47 1947

Immediate cause of death	Cerebro Sclerosis	4 days
Due to	Arteriosclerotic Changes Generalized	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Purnell, M.D. (M. D. or other)

Address: 100 W. Main S'bury, Md. Date signed: 2-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35